Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

J T DILGER JR MD
6718 MONTAY BAY DRIVE
SPRING TX 77389

Carrier's Austin Representative Box
54

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Date Received
JULY 8, 2009

MFDR Tracking Number
M4-09-A136-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: A position summary was not submitted by the requestor.

Amount in Dispute: $1,075.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. After review of the designated doctor report, mechanism of injury, and the operative report for treatment of the injury Texas Mutual has concluded that an additional $300.00 is due for the two additional body areas evaluated. However, Texas Mutual maintains its position regarding code 96118."

Response Submitted by: Texas Mutual Insurance Company, P. O. Box 12029, Austin, TX 78711-2029

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 8, 2009	99456-W5 99456-W5 99456-W5 99456-W5 96118	$350.00 $300.00 $150.00 $150.00 $125.00	$0.00 $0.00 $0.00 $0.00 $125.00
TOTAL		$1,075.00	$125.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers'

compensation professional medical services provided on or after March 1, 2008.

3. 28 Texas Administrative Code §134.204 sets out fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 3, 2009

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-47 – THIS (THESE) DIAGNOSIS (ES) IS (ARE) NOT COVERED, MISSING, OR ARE INVALID.
- CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
- 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE.
- 907 – NOT ALL DIAGNOSES SUBMITTED ARE RELATED TO THE COMPENSABLE INJURY, ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE.

Explanation of benefits dated December 31, 2009

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATON .
- CAC-47 – THIS (THESE) DIAGNOSIS (ES) IS (ARE) NOT COVERED, MISSING, OR ARE INVALID.
- CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
- 891 – THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION
- 907 – NOT ALL DIAGNOSES SUBMITTED ARE RELATED TO THE COMPENSABLE INJURY, ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE
- 920 – REIMBURSEMENT IS BEING ALLOWED BASED UPON A DISPUTE.

Explanation of benefits dated July 30, 2010

- CAC-22 – THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATON .
- CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
- 891 – THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION
- 907 – NOT ALL DIAGNOSES SUBMITTED ARE RELATED TO THE COMPENSABLE INJURY, ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE.
- 920 – REIMBURSEMENT IS BEING ALLOWED BASED UPON A DISPUTE.

Issues

1. The carrier has addressed issue of compensability for the claim. How does this denial reason affect the Designated Doctor (DD) Examination requested by the Division?
2. Has the Designated Doctor (DD) examination, CPT code 99456-W5 x 4, been reimbursed appropriately per 20 Texas Administrative Code §134.204?
3. Is the requestor entitled to reimbursement for CPT code 96118?
4. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. On the EOBs dated February 3, 2009, December 31, 2009 and July 30, 2010, the respondent denied reimbursement based upon "CAC-47 – THIS (THESE) DIAGNOSIS (ES) IS (ARE) NOT COVERED,

MISSING, OR ARE INVALID"; and "907 – NOT ALL DIAGNOSES SUBMITTED ARE RELATED TO THE COMPENSABLE INJURY, ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE." The respondent did not clarify or otherwise address the CAC-97 or 907 claim adjustment codes in the dispute resolution response, therefore the Division will review the billing per the applicable Division rules and fee guidelines in 28 Texas Administrative Code §134.204 with the review of supporting documentation.

Texas Labor Code §408.0041 states in part (a)(1)

(a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:

(1) The impairment caused by the compensable injury

Texas Labor Code §408.0041 states in part (h)(1)

(h) The insurance carrier shall pay for:

(1) An examination required under Subsection (a) or (f).

The completion of a Designated Doctor examination requested by the Division is payable per the above statute and is not subject to the status of the claim.

2. The requestor billed CPT codes 99456-W5 x 4 and CPT code 96118. The requestor did not submit any explanation of benefits (EOBs) supporting the carrier's denial reasons. The respondent submitted EOB's supporting that CPT code 99456-W5 for the billed amount of $150.00 x 2 was paid on the EOB dates December 31, 2009. The respondent also included a copy of the payment screen supporting these two codes were paid at $300.00 plus an interest amount of $9.38. A copy of the cashed check by J. Thomas Dilger, MD was also enclosed supporting the requestor received the payment. The EOB dated July 30, 2010 with CPT code 99456-W5 for billed amount of $350.00 and CPT code 99456-W5 for billed amount $300.00 supports that these codes were paid. The respondent included a payment screen supporting payment of $650.00 plus interest in the amount of $34.18. Therefore, the division concludes that the requestor was paid for CPT code 99456-W5 x 4 and is no longer in dispute.

3. Per 28 Texas Administrative Code §134.203, the calculations for CPT code 96118 is as follows:

   $53.68 WC CF/36.0666 Medicare CF x $104.43 Participating Amount = $159.43

   The total MAR for CPT code 96118 billed on January 8, 2009 is $159.43. The requestor's *Table of Disputed Services* lists $125.00 as the amount in dispute; this amount is recommended.

4. The respondent has previously reimbursed the amount of $950.00 plus interest in the amount of $43.58. Therefore the requestor is due a recommended reimbursement in the amount of $125.00 for CPT code 96118.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $125.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $125.00 per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 1, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.